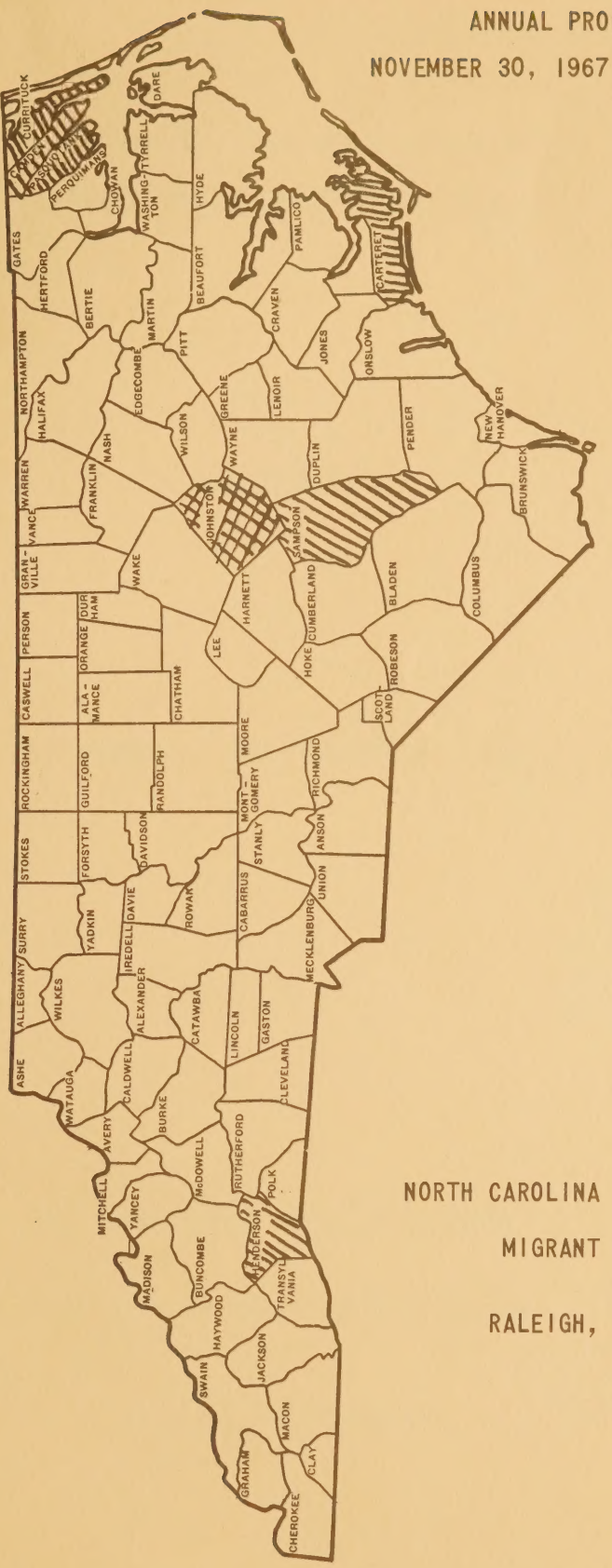
ANNUAL PROGRESS REPORT

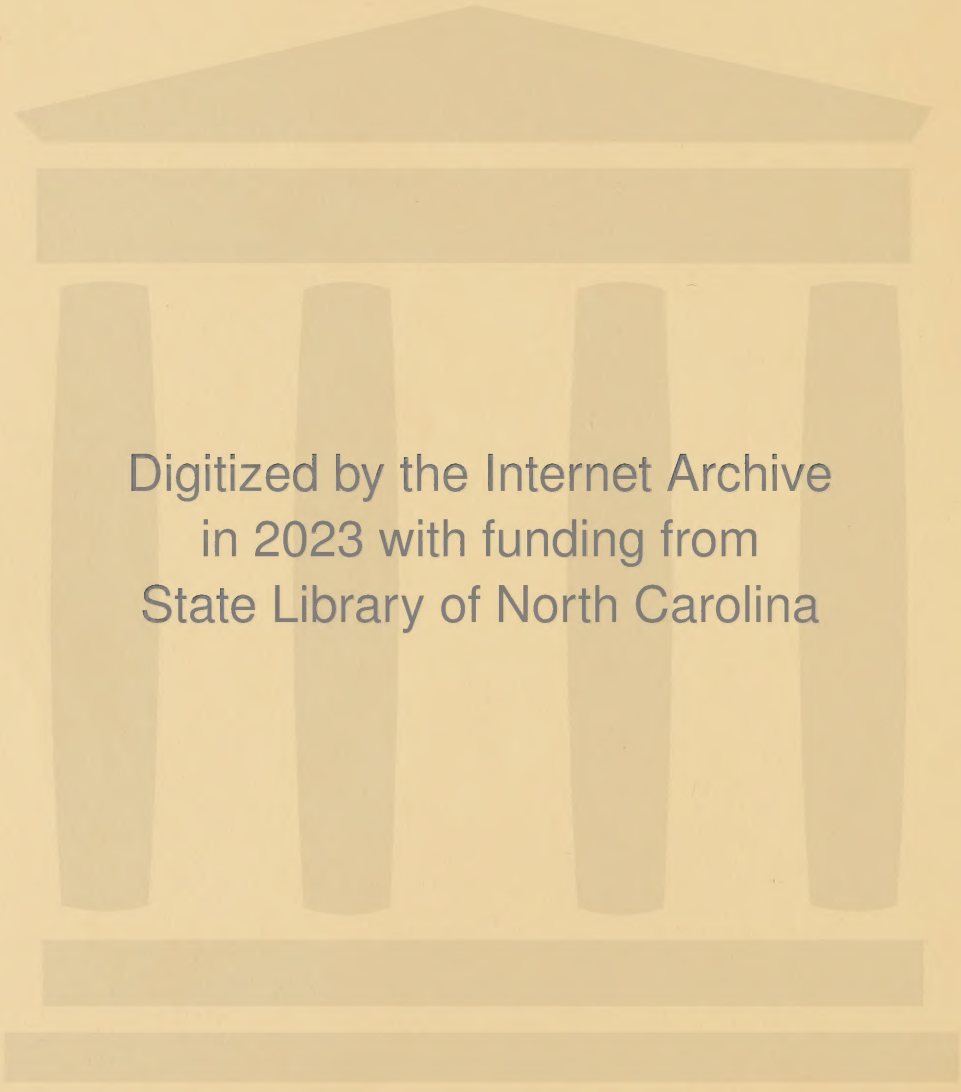
NOVEMBER 30, 1967 - NOVEMBER 30, 1968



NORTH CAROLINA STATE BOARD OF HEALTH

MIGRANT HEALTH PROJECT

RALEIGH, NORTH CAROLINA



NORTH CAROLINA STATE BOARD OF HEALTH

MIGRANT HEALTH PROJECT (MG-56-E)

ANNUAL REPORT

NOVEMBER 1, 1967-OCTOBER 31, 1968

DR. BURNS JONES - PROJECT DIRECTOR

NORTH CAROLINA STATE BOARD OF HEALTH

RALEIGH, NORTH CAROLINA

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NORTH CAROLINA STATE BOARD OF HEALTH

RALEIGH, NORTH CAROLINA

TABLE OF CONTENTS

NARRATIVE REPORT

NORTH CAROLINA STATE BOARD OF HEALTH MIGRANT PROJECT

This narrative is a brief synopsis of the Migrant Health Program of the North Carolina State Board of Health, covering the period from November 1, 1967 through October 31, 1968. Elaborations of the various activities of this program are to be found in the attached material.

The objectives of our Migrant Health Program are substantially unchanged from those articulated in preceding applications and reports. Unfortunately, implementation was not realized in one important ovjective - namely, establishing demonstration clinics and satellite projects in areas not now providing family health services to migrants. Lack of available funds is the principal reason for this 'deficiency. Nothing daunted, the North Carolina State Board of Health is resubmitting its plan for such projects in the hope that additional funds will be available for this purpose. A summary of a staff conference is appended to this narrative which lists and re-emphasizes the objectives of our agency as they apply to health services of migrants.

No significant changes in the migrant situation from the previous year are noted. There continues to be a considerable number of home-based migrants for whom services need to be made available, as well as those out-of-state migrants who come to North Carolina to harvest our crops. A depiction of this population and their various needs is included in the body of the report.

A general description of Project operations during the report year will list consultative, educational, promotional and advisory services to communities. Direct family health services are provided through local programs, reports of which are included in their own publications. One significant development that may be realized in the coming year is the adoption of Title XIX of Public Law 89-97 by the State of North Carolina. The implications of the Medicaid program must be carefully analyzed and its impact on present services must be incorporated for planning for health programs for migrants. Attention to this will be given within the coming year.

Relationships with communities, growers, other agencies, both official and voluntary, continue good. Continued emphasis on good relationships and communication will be continued. Consultation and other assistance from the Migrant Health Branch of the Public Health Service remains a helpful and valuable resource. The availability of assistance from both the Charlottesville Regional Office and the Washington Office is much appreciated.

Mention was made above to the lack of success in achieving the objective of establishing new programs in areas of family health services not presently available for migrants, which was occasioned by the lack of supporting funds. Other than this, the objectives of our program met with reasonable success. We are much strengthened by now being fully staffed with two full-time consultants in the field of migrant health activities. Although our other consultants who work in the field of environmental sanitation, public health administration, and public health nursing, maternal and child health, dental health care, health education, and other disciplines, continued their efforts on behalf of migrants, our program did suffer somewhat through the loss of our former migrant haalth consultant. Now that we have been successful in engaging two competent, dedicated, and active consultants for this program, we should hit our full stride again.

The North Carolina State Board of Health will continue in the dimensions of its present program of providing health services for migrants. We continue to believe, in the light of health needs of this group, that augmented support is necessary to make a maximum impact on the health problems of seasonally employed agricultural workers. To this end, we are again submitting a request for an additional central staff member and administrative officer to work full-time in this program, as well as requesting funds to subcontract the counties for the establishment of pilot demonstration and satellite family health service clinic. While our present efforts will not diminish, indeed will be augmented, it is felt that the promotion and development of health services to migrants will be materially advanced if these additional funds are made available.

OBJECTIVES

As a result of the discussions held on October 28, 29, 30, 1968 to review our state migrant health project, many useful points emerged that can be used as a foundation for building (up) the objectives of our project.

The State Board of Health Migrant Health Project has been working with the four local migrant health projects operating in the state of North Carolina. The state project provided help in orientation, training, consultation, placing, and technical supervision of aides, etc. to make these projects more effective. The working relationship between the state and the local projects must continue to be a direct function and responsibility of the state project.

The state migrant health project has also worked successfully with other agencies and groups interested in the migrants, through (a) co-sponoring conferences, (b) participating in the training of their staff, (c) keeping the channels of communication open for cooperation and coordination. This has been and should continue to be a necessity for well-organized work.

During the meetings, Mr. A. Beckham of the United States Public Health Service Migrant Section, explained how funds could be made available for building up satellite projects extending from the present local projects. This creates new challenges for planning of the program in the following years. The satellite projects will bring curative services to migrants in the areas of the satellites - the estimated number of migrants in those areas is expected to be a little more than 1200. These were not receiving curative services before. Mr. Beckham explained that the local project people should agree to extend the service when receiving additional funds for the purpose, that those of the intended satellite should accept the service, and follow-up care for patients should be provided.

This imposes new challenges to the state migrant health project and places additional responsibilities. The state project will act as a catalyst for and as a liaison between the two parties to promote the building of the satellite project in the areas.

The state project also has to help in solving the problems and obstacles resulting from this reorganization. In addition, the curative services (hospitalization and out-patient) would require a matching strong preventive service, which in turn requires the placement of additional personnel in some of these satellite areas.

Another important point emerged during these meetings concerned the North Carolina home based migrants and what specific services they need before joining the migrant stream and what could be done by their local health departments to meet these needs. The state migrant health project must necessarily help in the study of these specific needs and the ways to meet them. The state migrant health project should also make every effort to get the local health departments involved in seeing the needs of such migrants and plan specific services to meet the needs.

Some kind of a pilot project aiming at developing family health service adapted to these home-based migrants in one area was suggested. The experiences learned from such a pilot project could be used for better planning in the other areas where home-based migrants are concentrated. Bladen County could be a good place to start such a pilot project.

The participants in the meetings also took into consideration the possibility that other agencies may have to face changes in the type of services they had offered the migrants and how this could affect the State Board of Health Migrant Health Project. It seems probable that the North Carolina Council of Churches may cut their sanitation program. If this happens, the State Board of Health Migrant Health Project has to fill any gaps that are expected to occur in the sanitation services.

Basing on the above discussion we may draw some guidelines for preliminary objectives of our state migrant health project.

1. The state Migrant Health Project will continue to work with the local migrant health projects as before.

2. Promote satellite projects by working with local health projects and adjacent counties. Target satellites are Washington-Tyrrell-Hyde Counties, Johnston County

and Duplin County.

3. Involvement of the local health departments in:
   (a) initiating needed services for home-based migrants before they join the migrant stream.
   (b) understanding and appreciating the role of the health aide in migrant health work.
   (c) promoting services for interstate migrants, especially in non-project areas and adapting these services to the time schedule.
   (d) promoting coordination of health activities with other groups and agencies within the community.
4. Continue conferences that bring together agencies and groups involved in the service of migrants to review their activities and seek ways to promote their services and interagency relationships.
5. Continue to carry out a training program for crewleaders' wives, while participating in the crewleaders training school.

SANITATION

GENERAL

The best figures available indicated that we had approximately 15,000 migrants working in North Carolina during the 1968 season. This 15,000 is composed of 8,500 intrastate migrants and 6,500 interstate migrants. These figures were furnished by Employment Security Commission. We know that several thousand more "day-haul" workers were used, but no reliable figures are available.

SANITATION ACTIVITIES

The sanitation activities for this year have been basically the same as in previous years. These activities have consisted of working with growers in getting camps ready for occupancy, camp inspections, working with crew leaders and migrants in promoting better camp maintenance and sanitation. Again this year, we received excellent cooperation from the Employment Security Commission and the North Carolina Council of Churches Migrant Project. With a few exceptions, we feel that the sanitation level maintained at the camps was satisfactory.

The cooperation we received from the growers continued to be good except for a few isolated cases, and these were handled without court action.

Administrative

The administrative changes noted in last year's report have worked well. The job of Project Sanitarian is now a part time position and is handled by a District Sanitarian. The District Sanitarians are working with the local Sanitarians and have done a commendable job in handling the migrant program.

Statistical Information

In 1968, permits to operate a migrant labor camp housing ten or more were issued for 114 camps. The camps were located in 19 counties and housed approximately 3970 migrants. See Exhibit "A" for counties having migrant labor camps.

There are two counties which have local regulations covering migrant labor camps housing two or more but less than ten. In these two counties, there were 111 camps housing approximately 496 workers.

Figures supplied by the Employment Security Commission show 650 camps approved by them, and these were located in 35 counties.

There was excellent cooperation between the local Sanitarians and the Employment Security Commission in working together on approval of camps housing ten or more workers.

Field Sanitation

Field sanitation is an area that progress is very slow. Supporting data are not available, but we believe that the progress made since last year has been very slight.

N. C. Council of Churches Migrant Project

Technical assistance to the Project was continued. We received much assistance from the four Sanitation Assistants in the counties to which they were assigned.

Crew Leaders Schools

Two ten-week schools for crew leaders were held in Robeson and Wilson Counties. These schools were held at the Technical Institute and were sponsored by the Employment Security Commission and financed by Manpower Development Training Act Funds. Approximately twenty crew leaders attended each school. The Project Sanitarian and one District Sanitarian taught sanitation practices for one week at each school.

We feel that these schools are very beneficial because the crew leader can do more to control the sanitation level at his camp than any other person.

SUMMARY

1. The general level of sanitation at camps housing ten or more was adequate.

2. Migrant housnng for less than ten is good in the two counties having local regulations. We feel that the regulations of the Department of Labor on housing for agricultural workers and enforced by the Employment Security Commission will greatly improve the camps with less than ten.

3. Progress in field sanitation continues to be slow. We feel that rew ideas are needed before significant progress in this area will be made.

OBJECTIVES FOR 1968-1969

The objectives stated in the last year's report will be continued with some slight changes. We feel that the progress which has been made in migrant housnng and sanitation has been significant and, therefore, we feel that our past objectives have been sound and should be continued.

The objectives are as follows:

1. District Sanitarians will continue to work with the local Sanitarians on handling the migrant labor work in their District.

2. Continue the effective pre-season compliance checks and issue permits before workers arrive.

3. Promote better housing and sanitation in housing units for less than ten.

4. Continue cooperation with Employment Security Commission and give technical assistance concerning water supplies and sewage disposal.

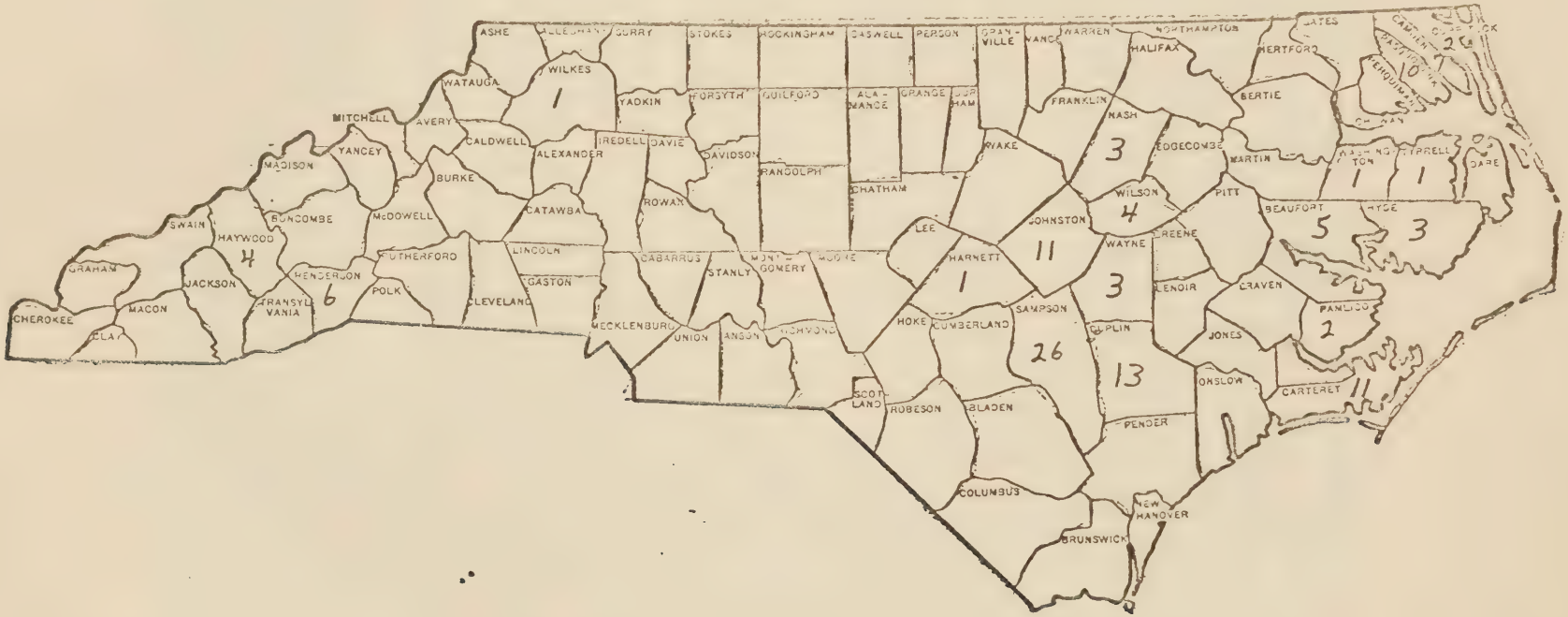
5. Continue to cooperate with, and give any assistance to, other agencies both public and private which are concerned with Migrant Labor Sanitation.

6. Due to the scope of Department of Labor's regulations on migrant housing, we do not feel that additional State regulations are necessary at this time.

EXHIBIT "A"

NORTH CAROLINA

MIGRANT LABOR CAMPS IN NORTH CAROLINA BY COUNTY - 1968



NURSING

During the latter portion of 1967 and early 68, administrative changes were made within the Nursing Section, State Board of Health, The nursing consultant assigned (Miss Judith Smith) to the Migrant Project was reassigned as a generalized consultant while a new consultant, Mrs. Esther Hatsell, was employed as nursing consultant to the Migrant Project.

Concomitant plans and processes were moving forward with both Miss Smith and Mrs. Hatsell participating.

Mrs. Hatsell combined orientation, i.e., State Board of Health policies, functions, and services with provision of consultation services to Migrant Project counties. Mrs. Hatsell met frequently with representatives of N.C.C.C., E. S. C. and local project staff to identify problems, i.e. recommendations from last year's experience, recruitment of new staff, orientation and continuing inservice for the purpose of seeking resolutions of these problems through coordinated planning.

The nursing consultant also actively participated in the now traditional annual N. C. Conference on Migrant Health. This conference brings together representatives from the entire State and serves as a forum for problem identification, and coordinated approaches to these problems.

Miss Judy Smith served on the Inter and Intra-State Referrals Committee and Mrs. Hatsell participated in USPHS Conference held in Washington, March 21, 1968. The results and processes recommended from this conference was shared with all nursing consultants for assistance in implementation in the state. Miss Smith and Mrs. Hatsell provided further nursing leadership as participants in the East Coast Conference on Migrant Health held in Orlando, Florida, March 26, 1968.

During the period from February to August, Mrs. Hatsell, in order to meet responsibilities of nursing component, State Board of Health Migrant Project, initiated and/or participated in 23 face contacts with administrative and managerial individuals and groups concerned with health of migrants in North Carolina. The content of these meetings ranged from locating resource persons for project orientations and inservice to revision of budgets and personnel policies. Also during this time the nursing consultant initiated and/or participated in 52 meetings and field visits with local project staffs. The content of these meetings varied from fields visits with aides to observe, supervise and recommend changes in personal care being given the migrants and family, to staffing patterns in clinic services.

Of significant importance in this year's project efforts was the nursing consultant's role in planning and assisting with implementation of the crew leaders school. Reports are still coming in from crew leaders relevant to the value of this educational effort.

In August, the nursing consultant assigned to this project was forced to resign because traveling the entire state with family commitments became too great a problem to be resolved.

By concensus of all nursing consultants, the State Board of Health, the major nursing problems relevant to Migrant Health Services are:

1. Recruiting personnel - all nursing personnel, but especially R.N.'s and those with public health experience

   Major obstacles: 1) short-term employment
   2) hours - both day - evening because of clinics
   3) working conditions - inexperienced R.N.'s afraid of camps, etc.

One project (Sampson) employed an LPN this summer - the first one in our projects, who worked very well. Perhaps we should consider more extensive utilization of L.P.N.

2. Need more nursing personnel written into projects (only 2 nurses in Sampson County - too much work for two people with the number of camps and clinics. Required to meet health needs. More auxilliary personnel could be used if training is within projects and carefully planned for.

3. Need better orientation programs for project nurses. This apparently will have to be done on individual or project basis because of variations in Project opening dates and Project Director preferences.

4. Poor nursing records - We do well with referrals and health cards, but family records, though improving, are poor in quality and quantity.

HEALTH EDUCATION

The health education consultant, Mrs. Barbee, resigned her post on November 1, 1967 and it was not until July 15, 1968 when the present health education consultant joined the project. The project remained more than eight months without a health education consultant, but health education aspects of the project were handled by Miss Grace Daniel, Chief of Health Education Section of the State Board of Health. This has prevented interruption of health education services of the project.

During the season the project employed two health education aides who were assigned to the local health projects at Currituck and Carteret Counties. Two others were employed and assigned to Johnston County (a report of their activities follows). The number of field health education workers including those employed by the local projects was seven. Two local projects enjoyed the services of professional health educators.

Miss Elizabeth Berryhill joined the health education staff in October, 1968. She graduated earlier as a public health nurse with graduate training in health education. From her office in Greenville, she will be very helpful to our project.

Objectives

The health education consultant made many field visits and continued to work closely with the Chief of the Health Education Section of the State Board of Health. As a result of this, the following objectives are seen to be the objectives of the project's health education service.

1. To provide consultation and technical supervision for field personnel in matters of health education.

2. To assess and evaluate the health education activities carried out with migrant groups throughout the state, with the intention of improving these services.

3. To help local projects in selecting suitable personnel.

4. To provide training especially for new personnel, retraining for other personnel when needed.

5. Facilitate communication between personnel of the different local migrant health projects and between them and those of other agencies involved in migrant work.

6. Help in selecting and in developing visual aids that suit the migrant population and in testing these aids and teaching materials before large scale production is attempted.

7. To help non-project counties with migrants see the need of the migrants and work toward meeting these needs.

8. Employ and place health education personnel where the need arises.

9. To work with health and other personnel on the state and regional levels toward detecting the needs and promoting the services with emphasis on health education services to the migrants.

10. To keep aware of any on-going or new programs, by any agency, that may have an impact on the health or welfare of the migrant population, clarify this impact and utilize it for the benefit of the migrants.

To achieve these objectives, the state health education consultants with the migrant health project has to work very closely with other sections of the State Board of Health espcially the Public Health Education Section, with regional consultants and personnel, with local staff as well as with the staff of many other agencies. The health education consultant joined the project a little late this season; however, the following activities were carried out.

Activities and Services

1. Several field visits were made to the local migrant health projects to get acquainted with these projects--their personnel, operations and the people they serve. The situation of health education was studied in these visits.

2. Visits were also made to non-project areas to assess the services and the health education needs, and to see how these needs can be met. The health departments personnel in these areas requested audio-visual materials designed for migrants specially on the problems of sanitation and personal hygiene. These aids help to strengthen their efforts in the health education of the migrants.

In some places it is also possible to employ health euucation aides and assign them to the local health department. The usefulness of this approach has been conclusively demonstrated in Johnston County (a report on that follows). When the number of migrants in the county is relatively small, the aide may work in two or more adjacent counties. These aides help to stimulate the local health department to see the needs of the migrants and how some valuable services may be adapted to meet these needs.

The health education consultant with the state project has visited, in addition to Johnston County, some other non-project counties. It has been noticed that not only the number of migrants, but also the areas of their concentration in the county are important factors in planning for these migrants. For example, the migrants in Nash County are just on the borderline of Wilson County and they are much closer to Wilson than to Nashville. Therefore, in planning for services to these migrants, it would be more feasible to consider them as migrants of Wilson County than of Nash County. The number of migrants in both was about 170 living in eleven camps.

The number os migrants in Duplin County during the 1968 season was comparatively high, about 543. These migrants need health services adapted to suit their needs and time.

3. The state health education consultant worked jointly with other agencies involved with migrants in an effort to strengthen their health education activities. Some good effort was done with the ESEA Program and with the North Carolina Council of Churches program. Our local migrant health projects maintain good working relationships with all agencies and usually well integrated and coordinated work results. The state health education consultant encourages this approach in all field visits and with all field staff and tries to find better ways for promoting this joint work and cpordinated effort. In one of the counties where a local migrant health project was in operation, the migrants came with their families and a large number of migrant children were enrolled in school. It has been reported to the health education consultant who was visiting the county that the ESEA program is working separately in matters of school health from the local migrant health project. The health education consultant discussed the matter with the project staff and then decided to invite the director of the ESEA program in the county for a meeting with the project staff the next day. She welcomed the opportunity and the meeting was held in the health department and was attended in addition to the local migrant project staff by the state health education consultant and the chief of Nursing Section/State Board of Health, who also was visiting the county. The meeting was held in a pleasant informal atmosphere and before it was over, plans were made on how to work cooperatively together in the next season. For example, as far as health education is concerned it was a common consensus that a small committee be formed in each school with representation from the teachers, the school nurse (school personnel) and the health educator (migrant project) to plan and follow up the health education of school children during the season.

The presence of the Chief of Nursing Section also focused attention on how the school nurse can work closely with the project and the health department nurses. Suggestions along these lines were made and appreciated by all.

On the state level, channels of communication are left open between the project and the ESEA supervisor. This cooperation is expected to result in promoted coordination in the field.

4. The health education consultant with the state project devised a form for seasonal reporting of health education activities to be used by our field personnel. The aim of the report is to provide a solid basis for evaluation of the effectiveness of health education work. (A copy of this form is attached to the report.)

5. The need for developing audio-visual aids that suit the migrants was in existence when the health education consultant joined the project. An audio-visual aid form was devised to help field personnel design the right kind of visual material by providing them with the necessary information about the problem and the group of people concerned. This form was devised late and was used only in Johnston County. It worked well and proved to be very helpful in designing the right and suitable teaching material. The form will be used next year by our field personnel, in an effort to develop and make available the right kind of teaching materials.

6. To be sure of the suitability of our teaching materials we made arrangements with the Johnston County Health Department to act as our center for testing the visual aids before we produce any on a large scale. The county was chosen because:

(a) it will have migrants till late November, thus giving us longer time to test

(b) it is close to Raleigh

(c) the photographic and slide production facilities are available

(d) an extension of service to the immunization aide was made to carry on with this activity, in addition to his normal activities

The cooperation of the Johnston County Health Department personnel in this respect is highly commended especially the efforts of the sanitarian who was very enthusiastic about this phase of the program.

There is a need for specific training of our field personnel in the skilled using, designing and producing visual aids. This need will be met in the orientation prior to the start of the season in each project area.

In this way we should expect soon a well organized system of providing and handling teaching aids designed specially for the migrants.

Consultation

This project was visited by Miss Cherry Tsutsumida, Health Education Consultant with the Migrant Section of the U.S.P.H.S. at Washington, D.C. on October 28-30. Miss Tsutsumida attended meetings with many staff members to review the North Carolina State migrant health project and made very useful contributions. Miss Tsutsumida also informed of some facilities available at U.S.P.H.S. office for helping in the development of some teaching aids. Another visit is scheduled for Miss Tsutsumida on December 16. Health education was also an integral part of the training and orientation activities due to the efforts of Miss Grace Daniel, Chief of the Health Education Section of the State Board of Health. A separate report on training activities will follow.

JOHNSTON COUNTY

GENERAL

This is a county in which there is a considerable number of migrants who live and work with more than half of them remaining in the county until late November. There is no local migrant health project in the county but two people were employed by the State Board of Health to work with migrants, one as a health education trainee, the other as an immunization aide and both were assigned to the local health department. These two staff members have demonstrated the need for such personnel especially in areas where no local migrant health project is in operation. Some of their accomplishments will be mentioned later in this report.

Johnston County is a place where the need for migrants is on the increase and in the last years we have had an annual increase of about 50 migrants. The total number of migrants during 1968 was 400 and it is expected to jump to 450 next season. Perhaps the reason for this is the steady increase in acreage by the fresh market vegetables coupled with the need for seasonal tobacco workers.

The migrant camps in Johnston County are today meeting the standards required by law. Five years ago the workers slept wherever they were able to find a barn or an old tenant house. During 1968, two camps were built with capacity to accommodate 35 workers each. A camp to house one hundred workers is in the planning stage and is expected to be in operation in the spring of 1969.

SERVICES TO MIGRANTS

The two people employed by the State Board of Health were dynamic in providing preventive health services to the migrants in such a way to suit the migrants needs and time.

Three clinics for chest x-ray and tuberculin testing were held during the season, at night. The cooperation of the nursing staff was great and led to the success of the clinics.

Sanitation services have been rendered to migrants throughout the season. The two staff members working closely with the sanitation supervisor at the health department were able to maintain good sanitary conditions in the camps and were also able to teach the migrants the health education components of sanitation.

Health Education was a major activity of both staff members. In addition to their work with the migrants, they also worked with community groups and were able to get the community involved. This involvement was reflected in the follow way:

(a) Community residents gave the migrants 275 mattress covers, 50 bed sheets, 25 pairs of pillow cases, and 40 pairs of shoes. All this was distributed free of charge.

(b) Community residents collected a great variety of magazines and distributed them to the migrants. They were well received by the migrants.

These two employees also developed a recreation project by making 50 checkerboards made of wood. The migrants enjoyed indoor games of this nature.

VISUAL AIDS TESTING CENTER

The Johnston County Health Department, with help from the two employees on the migrant project, is serving now as a center for testing our audio-visual aids before such aids are produced on a large scale for using with migrants througout the state. The department also serves as a center for slides production. This is reported; however, under the Health Education part of the report.

It is important to emphasize here that this kind of service is very important to the health education program with migrants throughout the state of North Carolina.

OTHER ACTIVITIES

The county has initiated during the season fourteen interstate referrals for persons who needed some kind of follow-up in other states.

FUTURE NEEDS

The increasing number of migrants in the county should call for another look on the services offered to these migrants. The need for medical and dental services is very urgent. Any future planning should consider the provision of medical and dental services to the migrants of Johnston County whether as a separate project or a part of another project already in operation.

TRAINING AND CONFERENCES

1. The Fourth Annual North Carolina Migrant Conference: was again cosponsored by the State Board of Health and the North Carolina Council of Churches. The conference was held early in April, 1968 with 57 participants representing the following agencies:

--Office of Economic Opportunity
--Employment Security Commission - - Farm Placement
--South Carolina Commission of Farm Workers
--Vocational Rehabilitation - - Raleigh District Office
--United States Public Health Service - Migrant Health Branch
--Public Welfare Department of North Carolina
--State Department of Public Instruction
--Community Action Fund, Incorporated (Florida)
--Representatives of different Divisions and Sections of the State Board of Health, and of the local health departments
--Representatives of the local migrant health projects
--Representatives of various sections of the North Carolina Council of Churches
--Agriculture Extension Service

The theme for this conference was "Evaluation". It was chosen because of the need to know what has been accomplished, how it has been accomplished, and how best can we achieve further progress in serving the migrants in the future. There was a need to review our methods and to explore new ones.

The opening address on "Evaluation" by Dr. Charles Cameron of the State Department of Administration--Comprehensive Planning--raised very interesting points which stimulated the lively group discussions that followed. Other speakers also enriched the conference by stimulating presentations.

Throughout the conference, participation was most active, and the comments of the participants on the progress and the achievements of the conference showed that it helped the personnel of the different agencies to understand each other's role more clearly; was informative and has had timely topics.

The conference had had the advantage of bringing together all agencies and groups concerned with the welfare of the migrants, and the planning committee of the conference reflected very well this team spirit and inter-agency cooperation.

2. TRAINING WORKSHOPS ON MIGRANT HEALTH

Some local projects start their activities earlier than other projects. It was seen therefore that the training workshops should be held locally. This will also give the local project staff the opportunity of going into camps and learning the actual services that their local projects offer for the migrants.

Training workshops were held in Elizabeth City and in Hendersonville for personnel of the two local projects in those areas. Plans are being made to enrich this training and to extend it to every staff member working for the migrants. Consultants from the State Board of Health participated in these orientation programs.

3. CREWLEADER TRAINING PROGRAM

This was the second school organized for North Carolina based crewleaders by the Employment Security Commission. It was held in February and March, 1968, in both Wilson and Robeson Counties. The aim of the school was discussed in last year's Annual Report; briefly the aim is to provide the crewleader with the necessary skills congruent with his role as a crewleader. In addition to participating in the crewleaders program the State Board of Health Project has this year initiated a training course for the crew-leaders wives.

The staff of the Migrant Health Project, North Carolina State Board of Health was given the responsibility for planning 20 hours of instruction for 40 agricultural crewleaders enrolled in the two MDTA Crewleader Training Programs sponsored by the Employment Security Commission. The two training programs were conducted at the Wilson County Technical Institute and the Robeson County Unit, Fayetteville Technical Institute. As in the previous Crewleader Training Program, the total course lasted ten weeks, with one half of each day devoted to remedial education skills.

Similar programs were conducted in each of the two schools. Subjects included were venereal disease control, tuberculosis control, accident prevention, alcohol education and first aid instruction. Consultants from different sections of the North Carolina State Board of Health served as resource people. The portion of the program (10 hours) devoted to first aid was taught by volunteers from the local chapters of the American Red Cross. These volunteer instructors one the Captain in charge of the Fire Prevention program in the local chapter, were able to adapt their programs to the speical needs of the crewleaders. In Robeson County eleven of the twenty students enrolled were able to earn the Red Cross certificate for completing the Basic First Aid Course. The general reaction to the entire program by the students and their supervisors was very favorable.

In addition to the program conducted for the crewleaders, in Wilson County this project sponsored a course in Home Nursing for wives and families of the student crewleaders. Each crewleader was invited to bring one female member of his family who traveled with his crew to participate in the course. These crewleaders wives were paid a stipend by the Migrant Health Project for their week's attendance. They attended the half day of health instruction being given to their husbands, and in addition had four hours each day of instruction in home nursing. The instruction was given under the auspices of the local American Red Cross chapter and entitled each woman who completed the course successfully to a certificate and a pin.

Arrangements were made to conduct these classes in a local church building because of limited space at the Technical Institute. Outstanding community cooperation made it possible to conduct this program. Equipment was loaned by the local hospital, a projector and screen were loaned by the local Alcohol Information Council and the local Red Cross representative located all necessary equipment and resource people.

Eleven women enrolled in the home nursing program and ten of these completed the program; the one dropout was a college student who ran into time conflicts. The course was received enthusiastically by the women. All the people involved in planning, implementing and participating in this program felt that the idea of reaching these women was very worthwhile and gave a great deal of support to the idea of the whole venture. Following this initial attempt at giving health knowledge and skills to the wives as well as to the crewleaders, it would appear that this type of program would be a very effective way to improve the health standards of the migrant population by developing leadership skills in their own group.

APPENDIX I

LOCAL MIGRANT HEALTH PROJECT

TENTATIVE HEALTH EDUCATION SEASONAL REPORT

REPORT BY: _____ PROJECT: _____

DATE: _____

I. GENERAL

1. Total number of camps in project area _____
2. Approximate number of migrants during the season _____
3. Approximate number of children (below 15 years) _____
4. Approximate number of school age children _____
5. Approximate number of adult women _____
6. What races or ethnic groups, their numbers:

   _____ _____, _____, _____

   _____ _____, _____, _____
7. States from which the migrants came:

   North Carolina, _____

   _____, _____

   _____, _____
8. Approximate number of migrants not living in camps _____
9. What groups or agencies were involved in the migrants health program in your area.

   _____, _____

   _____, _____

   _____, _____

II. SERVICES

1. What preventive health services such as immunizations, x-rays, well baby clinics, etc. are available to the migrants?

2. What health education activities were carried out to help the migrants to be aware of and utilize the health services?

3. What approaches and methods were used?

4. What were the contributions of other personnel in this respect?
   (a) Nurses role

   (b) Sanitation staff

   (c) Others

5. What health services were made available to the chronically ill--for both diagnosis and treatment?

6. What health education has been done in the field of chronic disease? What approaches were followed? What methods used?
   (Continue evaluation on following page)

(Evaluation of number 6 continued)

III. HEALTH EDUCATION AND THE FARM

The migrant worker spends almost all the day working on the farm. There are so many unhygienic practices as well as health hazards involved. These practices should be studied, diagnosed, and treated with health education.

1. What are some of the health problems or poor health practices connected with the farm or work situation of the migrants working in your area?

Problem or poor health practice

2. What health hazards or safety problems are possible on this type of farm or with this type of work?

Possible hazards	Type of work or situation

3. What health education was carried out to meet the problems of the above mentioned aspects, or some of the problems? Describe approaches and methods in connection with each.

IV. SCHOOL HEALTH EDUCATION*

In some areas there is a good number of migrant children enrolled in schools. The school, for many reasons, offers an excellent opportunity for education in health.

1. Do schools in your area (where migrant children receive their education) have any health education activities?

2. Do they have health education that is planned and co-ordinated? _____ With whom? _____

_____

_____.

3. If there has been such planning, have you had the chance to take part in it? _____

_____.

How? _____

_____

_____

_____.

4. What health education activities have the schools carried out during the season?

Items with an * may not be filled by Health Education Aides.

5. What visual aids have the schools designed and produced in connection with their health teaching? Have the children produced any of these?

6. What--in your opinion--would help to promote health education in the schools of your area?

7. What were the major health problems of school children? How do these problems relate to those of their community?

V. FAMILY HEALTH

Many migrants bring their families with them. These families have children of all ages--infants, pre-school children, school children, adolescents, etc. Also there will be sensitive groups like pregnant women and nursing mothers. This creates special needs in health education.

1. What health education has been carried out by your project directed at (a) Prenatal care, (b) Care of infants

2. What approaches and methods have been used in teaching baby feeding?

3. What feeding habits are usually practiced by family members? (Take into consideration the different ethnic groups)

4. What nutrition education has been done? What methods?

5. Any teaching connected with the healthy home environment and home safety?

6. What were the major health problems of:
   (a) Infants

   (b) Adolescents

   (c) Adults

7. What was the role of other staff (Health or others) in health education connected with the above-mentioned points?

VI. AUDIO-VISUAL AIDS

Audio-visual aids are aids (things that help.) They help the teacher in clarifying the problem or a certain aspect of it. They help the learner to understand what is being taught. To be effective, they should suit both the teacher and the learner. Different kinds of visual aids can be designed and used by the teacher.

1. Have you designed any visual aids during the season, produced or requested their production (by using the Visual Aids Form supplied to you at the beginning of the season?)

2. If yes, what kind of visual aids? Have you got them this season? If so, have you used them?

3. If you have used any visual aids that you designed, how did you use them and how effective or helpful were they.

4. Did you select or use any other visual aids (not designed by you) that were made available to you? What kind of visual aid? And how used?

5. Were these visual aids in item 4 above prepared specially for migrants?

VII. *If your project has made any efforts with the growers concerning the health of workers, please tell about the health education implications of such efforts.

VIII. *Have you carried out or participated in any efforts directed at making the local community understand the migrants and their problems?

IX. Any other health education activities not covered by the previous items.

X. Any suggestions or recommendations concerning ways of promoting health education work within your project.

APPENDIX II

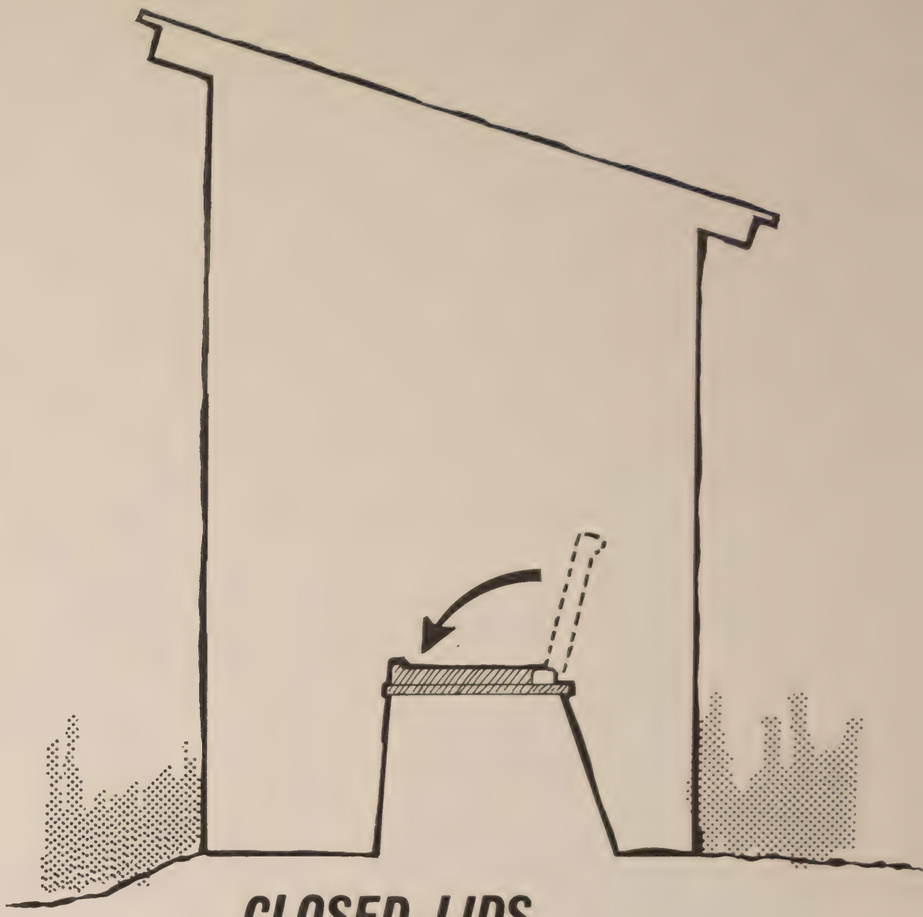
BROKEN GLASS CAUSES ACCIDENTS

Don't leave broken glass on the ground in camp or farm.
Put broken bottles in trash can.

NORTH CAROLINA STATE BOARD OF HEALTH

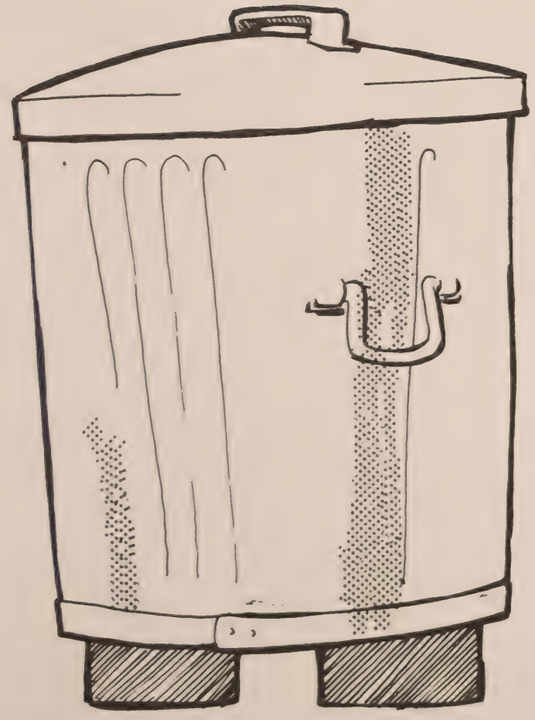
A CLEAN CAMP HAS

NO FLIES

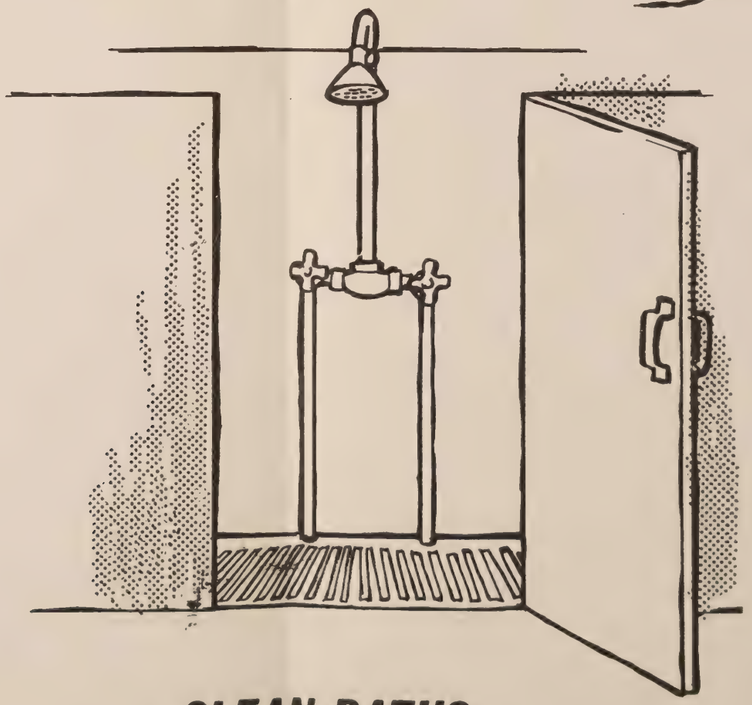


CLOSED LIDS

NO BROKEN GLASS

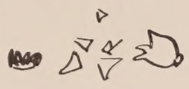
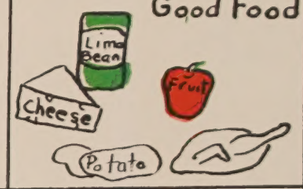
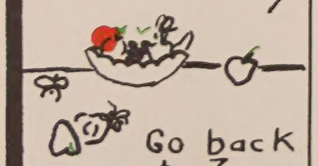


CANS TIGHTLY COVERED



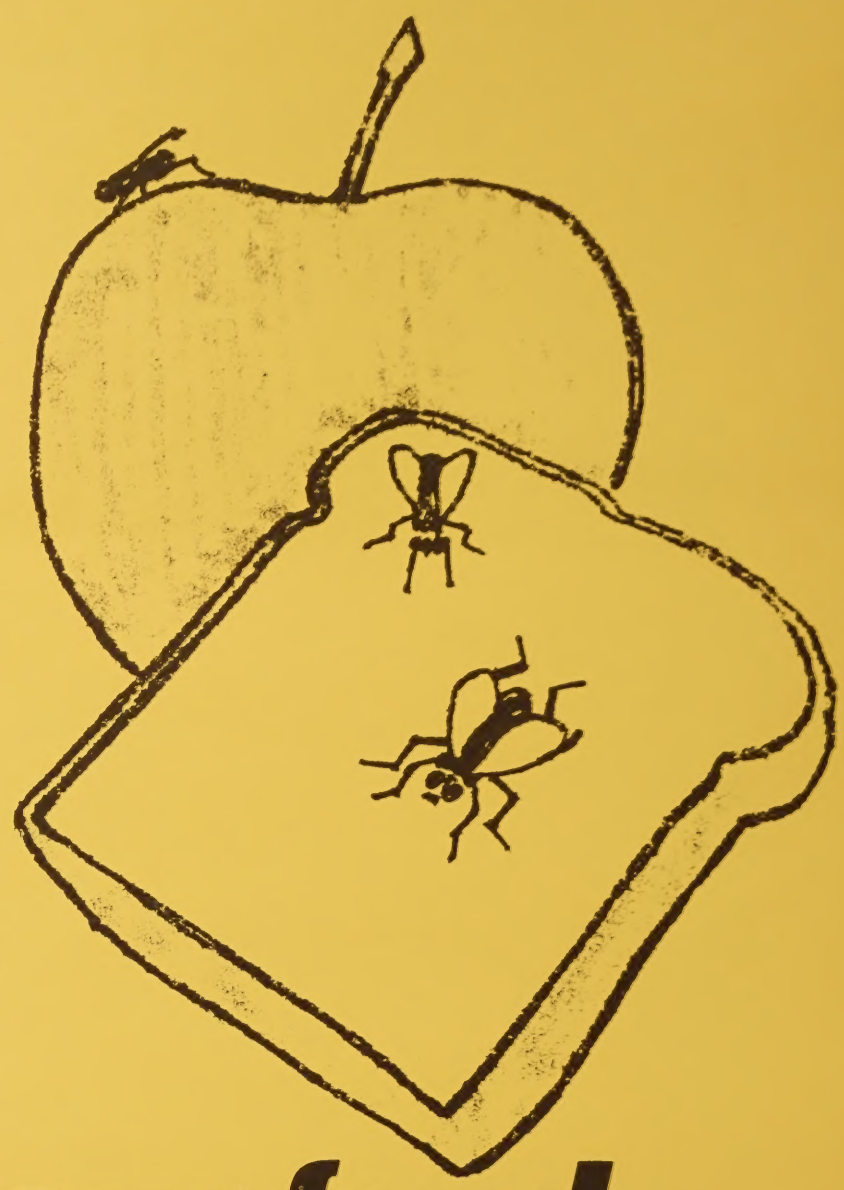
CLEAN BATHS

ROAD TO HEALTH

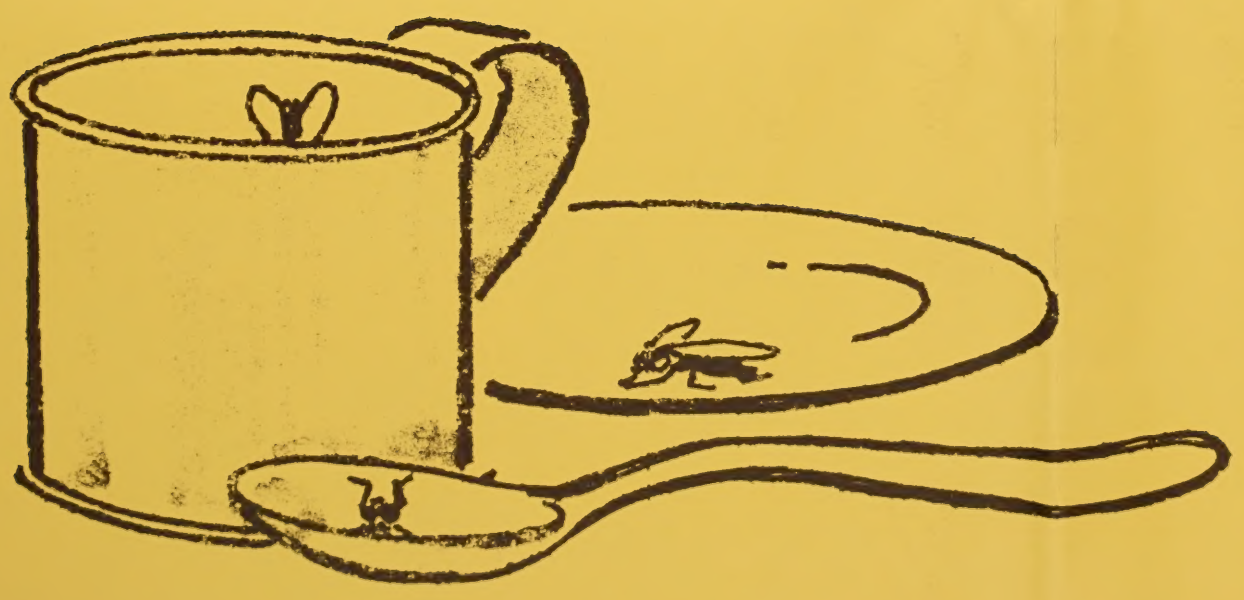
40	41	42  Jump to 47	43	44	45  Go back to 36	46	47 FINISH
39	38	37	36	35  Jump to 40	34	33  Go back to 20	32
24	25	26 Broken Bottles  Go back to 22	27	28  Jump to 31	29	Jump to 37 30 Good Food 	31
23	22	21  Back to 12	20	19	Good Clean Teeth 18  Jump to 27	17	16
8	9  Go back to 6	10	11	12	13 Jump to 15 	14	15
7  Go back to 3	6	5	Jump to 10 4 	3	2	1	 START

NORTH CAROLINA STATE BOARD OF HEALTH, MIGRANT HEALTH PROJECT, 11/68

FLIES CARRY GERMS INTO..



your food,



utensils,

baby's nipple or lips

& CAUSE DISEASE!